

# Challenges to Engaging Black Male Victims of Community Violence in Healthcare Research: Lessons Learned From Two Studies

Sonia Schwartz

Boston Medical Center and Boston University School of  
Medicine

Joel Hoyte

Tufts University

Thea James

Boston Medical Center

Lauren Conoscenti

National Center for PTSD, VA Boston Healthcare System

Renee Johnson

Boston University School of Public Health

Jane Liebschutz

Boston Medical Center and Boston University School  
of Public Health

A dearth of literature exists on barriers to conducting research with Black male victims of community violence, despite the need for evidence-based postinjury interventions. This study used qualitative data from a cross-sectional interview study ( $n = 16$ ) and a pilot intervention study ( $n = 11$ ) conducted in Boston, MA to identify challenges and facilitators to conducting research with Black male victims of community violence, particularly with regard to recruitment and maintenance of a study sample. Qualitative methods, including Grounded Theory and ethnography, were used to analyze the data. Challenges included a fear of police involvement, an impression of “snitching” when disclosing personal information, mistrust of research motives, suspicion of the informed consent process, the emotional impact of the trauma itself, and logistical issues. Facilitators to research included monetary incentives and motivation to help oneself and others. Participant recommendations on recruitment methods relating to approach and timing are provided. Findings from this study may assist in the planning of research studies for Black male victims of community violence.

*Keywords:* African American, qualitative research, community violence, research participation

Morbidity and mortality from stabbing and shooting violence disproportionately affects young Black males. In 2006, the firearm homicide rate for Black males ages 18–25 was 100.4 per 100,000 persons, more than five times higher than the rate for any other group (National Center for Injury Prevention and Control, 2005). Despite potential for social, behavioral, and other hospital-based

interventions to improve the treatment received by Black male victims of community violence, relatively few studies have been conducted in these settings (Becker, Hall, Ursic, Jain, & Calhoun, 2004; Cooper, Eslinger, Nash, al-Zawahri, & Stolley, 2000; Cooper, Eslinger, & Stolley, 2006; Zun, Downey, & Rosen, 2006). Moreover, little research is available to describe the specific barriers and facilitators to research participation in this population.

Two bodies of literature can help to inform this research gap. The first addresses conducting research with African Americans. This topic has been examined in a variety of samples, including cancer patients, general medical patients, and community members. Studies cite a lack of trust in medical research, particularly stemming from the Tuskegee Study, as a central barrier to conducting research with African Americans (Corbie-Smith, Thomas, Williams, & Moody-Ayers, 1999; McCallum, Arekere, Green, Katz, & Rivers, 2006; Rajakumar, Thomas, & Musa, 2009; Shavers, Lynch, & Burmeister, 2002). Other barriers include the belief that minorities have more risks in medical research, fear of risks to participating, inconvenience, perceived physician dishonesty, lack of perceived need for research, belief that African Americans would not benefit from any advancements a study may bring, fear of worsening health that may result in participation, and confusion of the purpose and meaning of informed consent (Corbie-Smith, Thomas, & St. George, 2002; Corbie-Smith et al., 1999; Dunlop,

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Sonia Schwartz, Section of General Internal Medicine, Boston Medical Center, Clinical Addiction Research and Education (CARE) Unit and Department of Medicine, Boston University School of Medicine; Joel Hoyte, Department of Community Health, Tufts University; Thea James, Department of Emergency Medicine, Boston Medical Center; Lauren Conoscenti, National Center for PTSD, VA Boston Healthcare System; Renee M. Johnson, Boston University School of Public Health and Department of Community Health Sciences; Jane Liebschutz, Department of Social and Behavioral Sciences, Boston University School of Public Health and Section of General Internal Medicine, Boston Medical Center, Clinical Addiction Research and Education (CARE) Unit and Department of Medicine.

Correspondence concerning this article should be addressed to Jane Liebschutz, Department of Social and Behavioral Sciences, Boston University School of Public Health and Section of General Internal Medicine, Boston Medical Center, Clinical Addiction Research and Education (CARE) Unit and Department of Medicine, 801 Massachusetts Avenue, 2nd Floor, Boston, MA 02118. E-mail: jane.liebschutz@bmc.org

Graham, Leroy, Glanz, & Dunlop, 2007; Shavers, Lynch, & Burmeister, 2002).

By contrast, there is much less published work on the second body of literature, barriers to research participation among community violence survivors. A study of a pharmacological intervention in acute trauma patients, including victims of violence as well as survivors of motor vehicle crashes and other accidents, showed difficulties enrolling trauma patients from the hospital; of the 569 accessible and potentially eligible patients, only 48 (8%) enrolled (Stein, Kerridge, Dimsdale, & Hoyt, 2007). The reasons for this difficulty in enrollment have not been explored, although informal discussions with patients by Stein and colleagues revealed several possible explanations, such as patients not wanting to participate in anything that may delay their discharge from the hospital and denial of possible mental health outcomes from a traumatic event (Stein et al., 2007). In a randomized controlled trial of victims of violent crime, only 243 (11.2%) of the 2161 patients responded to a letter sent by the study team (Rose, Brewin, Andrews, & Kirk, 1999). Investigators in that study felt that patients' unwillingness to share their experience of victimization with strangers may have played a large role in this low response rate.

Although these studies suggest issues that may be important when designing studies for Black male victims of violence, research is needed to examine whether there are unique barriers not previously identified, and how much previously identified issues impact research participation among victims of violence. To address these research gaps, we culled data from two studies to identify the challenges and facilitators to conducting interview and intervention studies with Black male victims of community violence. One was a cross-sectional qualitative study on interactions with health care after injury. The other study was a pilot intervention to link Black male victims of community violence to culturally appropriate mental health and primary care.

## Methods

### Participants

Participants from the cross-sectional study were recruited via flyers posted in community settings around Boston, MA through word of mouth from other participants, and via online posting (boston.craigslist.org). Interested people were screened for eligibility criteria, which included male gender, age 18–40 years, and history of a gunshot or stab wound injury for which they sought medical care. Although Black race was not an eligibility criterion, all participants who completed the study self-identified as Black. Thus, participants for the cross-sectional study included 16 Black males with a median age of 31 years (range 25–38). Three were victims of gunshot, five of stab wounds, and eight were victims of both injuries. The median length of time since the most recent injury was 5.5 years (range 4 months to 20.1 year). Eligible participants provided written informed consent. At interview completion, they received \$25 compensation and a referral list for local mental health and substance use treatment centers.

The second study was a pilot intervention that linked participants to primary care and provided a five-session problem-solving counseling program. Participants in the intervention study were recruited through a violence intervention advocacy program of an urban academic medical center with the largest Level 1 trauma

center in New England. Eligibility criteria included gunshot or stab wound that was treated via the Emergency Department in the prior 2 years, age  $\geq 18$  years, self-identified Black race, male sex, English language fluency, plans to stay in the area for the next 6 months, two forms of contact, and use of an illicit substance or hazardous amounts of alcohol in the prior month. Those who suffered a traumatic brain injury were excluded because of the need for participants to be able to engage in the counseling program. Participants for the intervention included 11 self-identified Black males with median age of 26 years (range 18–42). Two had been treated for a stab wound and nine for a gunshot injury that occurred a median of 23 days (range 1 day to 23 months) before study entry. One participant enrolled in both studies. Enrolled participants provided written informed consent and received \$25 compensation for each of three research interviews completed.

### Procedures

In the cross-sectional study, trained interviewers conducted 14 semistructured interviews from January through December of 2008 (2 paired and 12 individual interviews). Seven interviews were conducted by 2 Black, male, community-based mental health professionals, 3 by a White female research assistant, 3 by a Black male research assistant, and 1 by the White female principal investigator. To facilitate rapport, all interviews were scheduled with Black, male interviewers. However, two interviews occurred when participants showed up hours past the scheduled interview time, when the designated interviewer was no longer available. Two interviews occurred when the participants could not provide contact information to allow confirmation with Black interviewer schedules and thus were interviewed right at the time of inquiry by available trained staff. Interviews were digitally recorded and lasted 45–120 min. Audio recordings were professionally transcribed and identifying information was changed to preserve participant confidentiality.

The interview guide focused largely on experiences with health care during and after injuries. Once the investigators encountered recruitment difficulties, questions were added about views on research participation, particularly recruitment, starting with the third participant. The goals were to inform improvements to the recruitment protocol and to anticipate research conduct issues that might arise in the planned intervention study. Participants in later interviews were asked for clarification on concepts discussed in earlier interviews or about issues that came up during initiation of the intervention study.

In the pilot intervention study, data were drawn from detailed ethnographic field notes (Warren & Karner, 2005) taken by the research assistant on all contacts with participants over the course of their participation in this 6-month study. Notes explicitly focused on the process of research participation that could help assess feasibility of the program for future application. This included interactions relating to appointment scheduling, communication, family, transportation, and disability, as well as commentary on research from the participants.

Each study obtained approval from the Institutional Review Board at Boston University Medical Center and received Certificates of Confidentiality from the National Institutes of Health.

## Analysis

Grounded Theory methods (Glaser & Strauss, 1967; Strauss & Corbin, 1990) were used to analyze the data, wherein themes found in earlier interviews were asked about in subsequent interviews for clarification if they were not spontaneously mentioned. The racially and professionally diverse research team represented a range of viewpoints for data interpretation. It included 3 White members and 3 Black members, and consisted of 2 physicians, 2 college-educated research assistants, 1 clinical psychologist, and 1 professor of public health. Team members listened to and read over the interview transcripts from the cross-sectional study and the field notes from the pilot intervention multiple times to create a coding scheme. At least two members coded each cross-sectional interview using NVIVO v. 7 software (QSR International Pty Ltd), resolving coding discrepancies through discussion with another team member. The pilot intervention field notes were coded by hand by at least two team members, resolving discrepancies with another team member. A full coding scheme was created from the cross-sectional interviews before analyzing the complete data from the pilot intervention. However, the field notes offered additional themes and ideas, and were integrated with the cross-sectional interviews. In some cases, the qualitative interviews explained observations made of the intervention. Questions on interpretation of data were clarified weekly with two violence intervention advocates, including one with a history of a gunshot wound. Throughout both studies, the team practiced reflexivity (Maruta, Swanson, & Finlayson, 1979) by continuously attending to the feelings and biases that emerged for them throughout the research process.

## Results

Analysis of data from the cross-sectional and pilot intervention studies revealed challenges and facilitators to conducting research

with Black male victims of community violence. Themes related to challenges, facilitators, and recommendations are described below along with the social context in which they occurred. Challenges to research centered on mistrust of the research process in several contexts, including fear of police involvement, an impression of “snitching” when revealing personal information, mistrust of research motives, and suspicion of the informed consent process. Other challenges included the emotional impact of the trauma itself as well as logistical issues. Facilitators to research included monetary incentives and motivation to help oneself and others. Participants’ recommendations for recruitment are also presented. Unless otherwise noted, data came from the cross-sectional interview study. See Table 1 for a summary of these findings.

## Challenges

**Fear of police involvement.** When asked about barriers to research participation, 7 (44%) of the 16 cross-sectional study participants voiced concern about police involvement in the research process. In particular, they feared that police could obtain information from the study to use against the participant or make a case in the injury investigation. One participant commented, “Like . . . maybe the undercover police, they’re trying to find out the whole situation, what’s going on with the story. Or, they might feel that you may give this story to the police.” Another stated, “People think, ‘Oh, they’re trying to get some information from me. To get me caught up with the police or something like that.”

One participant attributed this concern of being approached for research while hospitalized to the timing of the police investigation relating to his injury, “. . . ‘cause most likely, the police usually come right after an injury. Then you guys come, so therefore, it’s like, ‘Well, the police just came. They might be connected to the police, too.’” This suspicion can lead some people to refuse speaking with anyone, as indicated by a participant who said: “I’m not talking to

Table 1

*Recommendations for Conducting Research With Black Male Victims of Community Violence*

Challenge	Recommendation
Fear of police involvement	Include on recruitment material: “Information will not be shared with police”; specify that you are not affiliated with police during initial approach and provide detailed information about the study to participant
Impression of snitching	Make privacy rules clear by reviewing rules again after consent, particularly relating to tape recorder or use of information
Mistrust of research motives	Provide information on purpose of research, funding and benefit to researchers Initial point of contact should be someone of similar background to potential participant—age, race, sex
Confusion of informed consent language (Principal) Investigator Privacy laws	Substitute with “research team member,” “research director” Talk to IRB about ways to clarify language in consent form or through a consent script to make it easier to understand; explain specifically how data and forms are kept private—“This consent form will not go in the file with the other information you give us.” or “We do not use your name on any of the forms other than the consent form”
Not open to discussing injury	Use mellow approach methods to first gauge the potential participants’ willingness to talk
Logistical problems	Flexible scheduling, expect that many appointments will be missed, will start late, or will have to be rescheduled Provide taxi vouchers Use separate study telephone not attached to hospital line

*Note.*  $n = 16$  for the cross-sectional study and  $n = 11$  for the pilot intervention. The confusion of informed consent language, privacy laws, and logistical problems are informed by the cross-sectional and pilot intervention study. All other points are informed by the findings in the cross-sectional study.

anybody . . . “cause I don’t know who they are, where they’re from and what they’re about.”

**Snitching.** Five (31%) participants in the cross-sectional study spontaneously mentioned the perception that talking to researchers is a form of “snitching” or “ratting” on somebody. This included the fear that information would be shared outside of the research setting, and that participants were being “set up”; responses indicated misunderstanding the rules of privacy. One participant said:

You don’t want to talk about it. You get injured, you’re like, “I’m not snitching. I’m not saying nothing to NOBODY. So, just talking to any study, or whatever, whatever, even though all the rules of the . . . of the study is . . . explain it’s confidential and all that, but at the same time, some people just don’t have their mind together and they think it’s a form of snitching.

The use of recorders in the interviews played a role in the concern for information getting released, “Then you got a tape recorder right there, I’m like, ‘Yo, what’s that?’ I don’t want to swear but what the ‘f’ are you going to do with that?”

**Mistrust of research motives.** Participants also noted that the motivation behind research was suspicious as exemplified by the language used to describe research, such as “there’s always a catch” and “conspiracy.” Two (13%) cross-sectional study participants identified research with lab animals, “You can’t sit there and treat people from the inner city like a bunch of lab rats in a tank.” Three (19%) participants discussed the belief that researchers have a “financial gain” in conducting studies:

“The results of this research may be published in a medical book by White people for White people, to further benefit from your misery.” That’s what [the consent form] should state, like, [the research assistant] . . . is conducting this study, which is a LIE! So, why wouldn’t she? She’s . . . she’s from [a hospital], right? With the rest of the White people that profit from all this misery? Very beneficial business.

This “profit” was assumed to benefit only the researchers, and not the participants or community, “Okay, it’s a research study, they’re gonna take my information and probably benefit, you know, from me, on a financial gain, and, you know, what am I gonna get out of it?”

**Informed consent.** Participants in both studies doubted the privacy protections provided by informed consent. It is important to note that all participants in both studies had undergone an informed consent process before the interview. One participant in the cross-sectional study said:

‘Cause some people can say, “Yeah, this is a consent form, and we’re not gonna give any information back,” but then some people have different doubts, and they really think it’s a situation like, “Well, I don’t know, they might be trying to set me up in this situation.”

Language of the consent form played a large role in this misunderstanding. During the pilot intervention, one participant signed the consent form. Later, he showed his copy to his mother. The next time the research assistant contacted the participant, he explained that his mother was concerned that his information would not be kept private and confidential AFTER she read the consent form, particularly the clauses that describe when researchers would be required to report private information. The research

assistant explained the privacy laws again to both him and his mother, and the participant decided he would continue to participate. Additionally, the peer advocates working with the researchers noted that some study participants visibly tensed when hearing the words “principal investigator” read by the research assistant, as this term sounds similar to law enforcement terminology.

**Not open to discussing injury.** Another challenge to getting victims of community violence to participate in research relating to their injury was the emotional difficulty of talking about the injury. This concept was mentioned by 5 (31%) cross-sectional study participants. In the aftermath of the injury, victims of violence may understandably need time to sort out their feelings about the events. Feelings of fear, anger, disrespect, shock, and trauma were all mentioned as reasons why one may not want to participate in research soon after an injury, “After something happens to a person, depending on what happened and circumstances, it takes awhile for them to really get over the shocking point of it. You know what I mean? So it’s like . . . ‘give me time to BREATHE!’”

Participants mentioned the importance of taking into account the situations they encountered during the injury episode when approaching them about a study related to their injury, as this may affect their willingness to talk to unfamiliar researchers about what happened, “Like, Lord knows what might have happened when that person got shot. Like their best friend could have got killed and they just got injured, and they don’t want to talk to nobody.”

Because many victims of community violence are injured at a young age, one participant suggested that willingness to talk about the injury may also relate to the maturity level of the person at the time of the incident:

Like, back then, I wouldn’t have had time because I would rather be playing, than sitting up with somebody and talking for an hour. Like now, like, I’m grown, now. Like, I could sit here and converse with you for an hour.

In addition to not wanting to discuss an injury right after it occurred, 4 (25%) of the cross-sectional study participants talked about the emotional pain that can come from bringing up the events of an injury that may have occurred several months or years ago, “You know, it hurts some people to think about it, you know? And their mind starts having flashbacks, you know? I’m dealing with them . . . memories that you’re trying to suppress.”

**Logistics to research execution.** During the intervention study, the field notes demonstrated a series of logistical challenges to working with this population, including scheduling appointments, telephone communication, and transportation. Appointments were scheduled to fit the needs of participants. Two (18%) of the 11 intervention participants had reversal of a day-night sleep cycle because of issues such as nightmares or an unstructured lifestyle, so they could only meet in the afternoons. Four (36%) intervention participants did not like to get home close to, or after, dark for fear of safety, so they requested morning appointments. Two (18%) intervention participants had childcare responsibilities and could only meet at certain times or days. Finally, on numerous occasions, participants did not show up at all or called at the time of the original appointment to change the time.

Telephone communication proved to be difficult throughout both studies. Participants rarely answered telephone calls when the caller identification showed a hospital telephone number. To address this issue, the study team purchased a cellular telephone for



the study, and noticed an immediate increase in the number of calls answered and returned. Of the 20 unanswered calls made using the hospital telephone for the intervention, just 4 (20%) were returned. By contrast, 4 out of the 9 (44%) unanswered calls from the study cellular telephone were returned. In addition, the hospital database of contact information was often incorrect. When asked about this in the cross-sectional study, one participant explained that providing inaccurate contact information reflected the "G-code," signifying a "gangster" code.

That's . . . that's like sticking to what they call in the street, is like sticking to the "G Code." They . . . people just wanna get . . . get help that they need or whatever. But they don't want to . . . they don't want to participate in stuff, like the studies like this because they think this is like a form of snitching.

This participant explained that patients will be polite while getting treatment but may give a false telephone number to prevent any follow up contact.

Another issue stemming from telephone communication was the inability of some participants to maintain cellular telephone minutes. Three (27%) out of the 11 intervention participants lost their jobs after their injury and were unable to continue paying for their minutes. Four (36%) never had a steady income and it was unclear when cellular telephone minutes would be added back to the telephone. A second contact number was always taken at the screening for both studies, however, participants were not always available at the second contact, did not regularly stay at the location of the telephone, or it was the number of a person they might or might not see during the course of the study, like a parent or case manager.

A third logistical issue was transportation difficulty. Few participants had their own vehicles. All participants in the pilot intervention and 3 out of 16 (19%) in the cross-sectional study noted the fear of taking public transportation. At least one participant in each study was injured while on public transportation, and others were aware of the potential vulnerability while taking public buses or subways. One participant in the cross-sectional study describes his reaction to the police wanting him to take the bus down to the courthouse to testify as a witness:

But, you know that, after . . . after something like this happen, there's no way you expect me just to get on the regular public transportation and come on down to the courthouse. That's unrealistic. That was like a death trap right there.

Physical disability can also affect transportation. Among the 11 intervention participants, 1 was paraplegic because of a spine injury, while 6 (55%) had leg injuries. This made traveling by public transportation or walking to the appointments challenging. To overcome both issues, taxi vouchers were provided in the pilot intervention for travel to and from appointments. Positive feedback was received from the pilot intervention participants regarding the vouchers, and none missed their medical appointments.

## Factors Facilitating Research

**Monetary incentives.** When inquiring about facilitators to recruiting victims of violence for research, 7 (44%) of the 16 cross-sectional participants responded with some type of incentive, money being the most common. One participant stated, "I wouldn't do it if it was for free. I'd be like, 'I'm not gonna waste

an hour of my time to like tell somebody about getting shot, and like get nothing out of the deal.'" Examples of nonmonetary incentives included counseling referrals ("So, you want to advertise, throw that out and say, 'Well, so, for our research, we'll also seek you help.'"), gift cards to toy stores ("I know that money's gonna go to my daughter"), movie passes, and food.

Participants mentioned not having a place to live, financial need, school loans, and the economy as some of the reasons for the importance of monetary incentives, "And it's sad to say that \$25 might be life-altering at one time, another. They might need that money to go to work, or day labor, or whatever have you." One talked about the importance of compensation because it makes a person feel like they are participating in something meaningful: ". . . the money gives them the incentive to really feel like they're doing something."

**Motivation to help oneself.** Another reason why participants wanted to do research was they felt it would be beneficial to their own life. According to one participant, "You don't know what you might get out of it." Four (25%) cross-sectional participants believed that accessing resources through an intervention study, particularly counseling, would be a good incentive to participate in research.

However, when you have a lot of people around you with a lot of feelings, you know what I mean, a lot of support . . . you know what I mean, it's gonna bring you to that point where you could get, you know, get . . . a little bit out of it. I'm not, I'm not saying all of it; a little bit out of it.

Conversely, not recognizing the personal benefits of research was also mentioned as a reason why one may not participate in a study. One participant said, "And I think most people'll go, 'Oh, f\*\*k it. I ain't gonna go in there and tell them my God d\*\*n life. Forget that. No, no, no. They, they ain't gonna do nothing, no way.'" Another explained, ". . . it's like, 'Well, I need my self-helped out. So, why would I want to help this person out if I can't get helped out?'"

**Motivation to help others.** Six (38%) cross-sectional participants also talked about wanting to help future victims of violence and their community as an incentive for participating in research, "At least you're being open to giving you suggestions and making things better for, not, maybe not yourself but somebody else later on down the line." One participant said he wanted to help researchers gather information with the hopes that more studies will develop from the new information. Seven (44%) cross-sectional study participants talked about the societal benefits that can come from someone participating in research, and six (38%) thought researchers should mention the potential societal benefits during the recruitment process to help people decide on whether or not to participate.

I would say just, um . . . explain it in detail how, by their feedback, can contribute to the research study, to be beneficial for just . . . for society, in general, because it is a research study, and any research study that you do, if it's really successful, the whole . . . the society in general can benefit from it.

## Participants' Recommendations for Effective Research Recruitment

**Recruitment approach.** Two main components to recruitment approach included specific behaviors and the demographic

make-up of researchers with initial patient contact. Participants suggested a mellow approach that begins with a brief introduction. It was important to acknowledge that the potential participant is injured by first inquiring about how they are feeling during the introduction, "I'd start off with flyers, and just giving them the brochure about, what we're about and what are we trying to do . . . Give them . . . and say, make them feel comfortable."

Two (13%) cross-sectional study participants suggested that family may play a role in recruitment. This was apparent in the intervention study, as several participants had their mothers or girlfriends present during the enrollment process and asked these women to come to appointments or help schedule appointments. "So, if you have a family member—somebody's mother, sister, girlfriend, wife—they could persuade them and point them in the right direction and tell them . . . without them have to think about it and evaluate the situation their self."

Two (13%) in the cross-sectional study suggested that the person approaching the potential participant should be someone who appears to come "from the same situation" or be of the same racial background so as to enhance the comfort level.

Well, I can tell you, for . . . if there was a young Black male sitting in that hospital bed, you bet, you know, your chance would probably be better sending in the youngest Black male person you have workin' for you. 'Cause . . . I know for sure, man, it's all about eyes. And the first thing you see. Before you even open your mouth, I'm seeing you. And if you look different, or if you look, you know, something that I'm not used to seeing, I'm automatically gonna shut down about this much.

The researchers should take great effort to clarify that they are not affiliated with police officers when approaching potential participants in the hospital. Participants suggested providing information about the study to make this distinction.

So it's all about . . . really . . . showing them that, "We don't mess with the police. That, we don't talk to them or give any information that you give to us TO the police." You know what I'm saying? If you really can prove that to that person . . . you'd get like . . . more people to come in and see you.

Participants also emphasized the importance of making the person feel like this is an "honest situation" and "productive." One talked about offering a study that fits the needs of this population,

A lot of people need . . . need, need networking and, you know, resources. I mean, if you're just coming to sit there and talk to me, hold my hand, I mean, that's . . . I could call my girlfriend for that . . . a lot of these young cats feel like they don't have too many options. Or, you know, a lot of them don't have a direction yet. So, it all depends on what you're coming to the table with.

Participants said that in the initial contact, researchers should give patients a brochure with a telephone number where they can be reached. Leaving a number on the brochure may help recruit people who plan to follow through on the study. When discussing the content of the recruitment material, some talk about the language that should be included. One participant said the brochure should, "cater more to the actuality of their situation . . . You have to get them inspired first."

**Timing.** Timing of recruitment was also an important factor given the multiple stressors following an injury: "And reach out when the time is RIGHT. You know what I'm saying? You reach

out when the time is right, you'll find people who . . . who are definitely sincere with their injuries and WANT to talk about it." Reasons cited as to why it might be difficult to recruit from the hospital included injury severity, adjusting to new medications, legal issues stemming from the incident, anger, maturity level, and trauma from the injury, "Under them circumstances? You, you are not trying to have that conversation. You know? You're just trying to get taken care of, and . . . you're probably tired, angry, confused . . . you know, just like, want to be left alone."

Eight (50%) cross-sectional participants talked about the emotional sensitivity they felt after their injury that likely would have inhibited them from signing up for a study in the immediate aftermath, with anger specifically mentioned by four participants, "Some people, when you talk to them about a situation, they just get more angry. And if you don't be careful, they'll take it out on YOU!" Participants suggested how long to wait when approaching potential participants that ranged from having time to "rest" and "get comfortable" in the hospital to after "recuperating and settling in" at home.

## Discussion

This paper reports on challenges and facilitators to conducting research with Black male victims of community violence. Although some challenges are likely to be common to all populations (e.g., scheduling logistics), the most potent challenges for research participation seen in these studies relate to the inner city street culture in which many of these men are immersed. These barriers, including fear of police, an impression of snitching, and mistrust of institutions, may be explained by what sociologist Elijah Anderson refers to as the "Code of the Street" (Anderson, 1994). He defines this as a set of rules found among inner city Black communities in response to the perceived failure of mainstream institutions to serve their needs, including law enforcement agencies. This Code encourages youth to take control of their own safety by protecting themselves instead of seeking help from, or cooperating with, the police; speaking to the police is viewed as defying the Code. Instead, violent injury may lead victims to carry weapons or seek retaliation to protect themselves (Rich & Gray, 2005). Those who do seek help from law enforcement after an injury may be viewed as weak and unable to defend themselves and vulnerable to future attacks. Black male victims of violence may or may not be actively involved in gangs or street violence. According to Anderson, however, even those who do not have gang affiliations may have shared mistrust of police (Anderson, 1994). This emphasizes the recommendation that research personnel clearly show they are not affiliated with police in printed recruitment materials and via personal reassurance by those conducting recruitment so participants do not feel they are helping police build a case against the perpetrator of their injury by participating in research.

"Stop snitching" is a campaign started among inner city youth meant to discourage cooperation with police regarding investigations into criminal activity (Schorn, 2007). This slogan can be found in music, movies, and clothing. As many study participants mentioned, research participation can be viewed as a form of snitching, particularly if people believe the information is shared with police. Ensuring that participants clearly understand the privacy rules may help alleviate some concern that information can be shared outside of research teams. This may be particularly relevant among participants who use illicit substances, which was an entry criterion for the pilot intervention. However, as seen in this study, the current informed consent

process may not be clear to those who do not typically engage in research.

Concerns about privacy and informed consent are not a novel finding. In one study of African American patients from public and private primary care clinics, participants who reviewed a consent form containing Health Insurance Portability and Accountability Act (HIPAA) authorization were less likely to consider taking part in the study than those who reviewed a consent form with no HIPAA authorization because of mistrust toward the research, research personnel, or research institutions (Dunlop et al., 2007). Working with Institutional Review Boards to make privacy clauses more understandable may help recruit and maintain participants in research studies, particularly with populations that may have issues with trust and privacy. In addition, obtaining a Certificate of Confidentiality from the National Institutes of Health may alleviate some concern of information being shared with law enforcement agents because of the protections it provides. However, researchers need to use terminology that participants understand when explaining the Certificate's protections and be aware of similarities to terminology used by law enforcement.

Previous research has noted the barriers to conducting health care research with African Americans, particularly the mistrust in research institutions (Corbie-Smith et al., 1999; Rajakumar, Thomas, & Musa, 2009; Shavers, Lynch, & Burmeister, 2002). Contributing to this mistrust is knowledge of the Tuskegee study, which may negatively influence people's willingness to participate in research (Shavers, Lynch, & Burmeister, 2002). However, because none of the participants in these studies mentioned this as a reason for mistrust in research and they were not specifically asked about Tuskegee, it is unclear the role it plays among this particular population. Cultural mistrust, stemming from historic and current experiences with racism (Whaley, 2001), may also discourage African American research participation. Studies have shown that African Americans with high levels of cultural mistrust prefer working with Black clinicians and may not be comfortable disclosing personal information to White clinicians (Townes, Chavez-Korell, & Cunningham, 2009). This may relate to sharing personal information to a White research team member. Additionally, among Black male victims of violence, the mistrust in research may also relate to the Code of the Street and fear of getting arrested, reinjured, or killed if a participant discloses too much about the injury circumstances. The importance of cultural competency is often emphasized when conducting research with minority populations (Cooley, Boyd, & Grados, 2004). Awareness of and sensitivity to street culture should be considered when working with inner city populations who may be influenced by the Code of the Street, as well as the influence of cultural mistrust on African Americans' willingness to disclose information. Having a research team member that potential participants feel they can trust may help engage them in research.

Another challenge noted in this study was the difficulty recruiting patients in the early aftermath of the injury. Several factors may influence this, including emotional outcomes experienced after a traumatic event, such as peritraumatic distress and peritraumatic dissociation (Fein et al., 2002; Fein, Kassam-Adams, Vu, & Datner, 2001; Johansen, Wahl, Eilertsen, Hanestad, & Weisaeth, 2006). Logistical issues demonstrated a need for flexibility in scheduling follow-up appointments that related to an injury, such as sleep disturbances, because of physical and emotional outcomes of the injury. The challenge of recruiting victims of violence in the aftermath of the

event corroborates findings in other studies working with trauma survivors (Stein et al., 2007). Scott and colleagues tested a study design that considers issues in research with trauma survivors that were found in this study, such as mobility and safety concerns (Scott, Sonis, Creamer, & Dennis, 2006). Similar to Scott's study, researchers should explore different research models for recruiting and randomizing victims of violence in the aftermath of the trauma.

Participants' desire to help others may be an avenue for which studies can increase recruitment. This has been seen among victims of other traumatic experiences (Campbell & Adams, 2009). In our study population, this desire may also stem from the idea of collectivism, the belief that the group or family is at the core of a society (Oyserman, Coon, & Kimmelmeier, 2002), a concept that has been found to be higher among African American populations (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). People with a strong sense of collectivism put their community before themselves and value loyalty, respect, and helping others (Kaniasty & Norris, 2000; Kreuter et al., 2003). Helping Black male victims of violence understand that participating in research can potentially help their community may help increase enrollment into research.

Findings from this study also reveal the high level of financial need among this population. While some may have had this need before their injury, because of the low-income environment from which they came, many were unable to work after their injury because of new physical and emotional disabilities. Communication was a common challenge with study participants, particularly because of the lack of steady income that may otherwise pay for a telephone or the unstable housing that would otherwise provide a steady telephone line. This made it difficult to stay in touch with participants and led to lost participants and rescheduled appointments. Participant availability has been an issue in other studies recruiting inner-city victims of violence because of the frequent mobility found in this population (Zun, Downey, & Rosen, 2006). A study looking at the psychosocial needs of victims of violence found the highest needs to be educational and occupational (Zun & Rosen, 2003). Study incentives catering to the needs of this population, such as money or telephone minutes, may play an important role in getting inner city victims of violence to enroll in studies. Using cellular telephone minutes as an incentive may have dual benefit, both for the participant, as well as for scheduling follow-up appointments.

Through the reflexivity practiced by the research team, investigators tried to be sensitive to what they were asking of participants, especially given the emotional trauma many participants had experienced. It may be appropriate for researchers working with this population to communicate empathy about the burden participating may place on potential subjects. Investigators may also want to emphasize that they are dedicated to preventing violence and assisting victims of violence, and not just there to "profit off participants' misery." They may also comment on the timeline for implementation of changes based on the results so participants do not feel that they provided information with no outcome for themselves or their community.

This study has several limitations. One is the small sample size, which in part may have been influenced by some of the barriers discussed in the results. Information was collected only from those who actually participated in research, thus, information on those who did not participate was gleaned from observation in the intervention component or by conjecture of participants who described how they felt when they were younger. However, a research bias exists toward those who were truly willing to participate in research. In addition,



this data has geographic limitations of an inner-city population in the Northeast, and may not generalize to other locations. The data also may not generalize to Black males who come from more educated, higher socioeconomic, or less urban backgrounds.

In the cross-sectional study, some participants were interviewed by White researchers, which may have influenced their willingness to disclose personal information if they had a high sense of cultural mistrust. The research team included both White and Black members, which may have had inadvertent bias toward the development of codes and themes based on racial or other experiences. To mitigate this, all members of the team reviewed all iterations of the manuscript to ensure that the views represented their own understanding of the issues. The team felt that the differing view points helped articulate, clarify, and interpret findings for each other. In particular, grasping the ramifications of the profound level of mistrust in research and health care systems in study participants spurred a change in consciousness among some team members.

Despite these limitations, this study attempts to provide information that will help in future research with Black male victims of community violence. As a qualitative study, the results provide information on which to base hypotheses for future testing. Future research should test study designs that incorporate the recommendations provided by our sample to see if they lead to greater recruitment, such as timing of recruitment, providing appropriate incentives, and creative communication avenues that may help with scheduling and follow-up. When working with this population in general, researchers should attempt to establish trust by involving peers in the recruitment process and by specifying that they are not affiliated with law enforcement; this may address some of the barriers to research participation. Finally, future research with Black male victims of community violence should be mindful of the cultural context in which these men have grown up and the emotional effects of the traumatic experience. Novel protocols should be adapted to fit within these contexts to maximize their effectiveness.

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Received March 6, 2009

Revision received January 25, 2010

Accepted January 25, 2010 ■

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